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Report to the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives

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LONG-TERM CARE FOR THE ELDERLY

Issues of Need, Access, and Cost

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Human Resources Division

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November 28, 1988

The Honorable Claude Pepper
Chairman, Subcommittee on Health
and Long-Term Care
Select Committee on Aging
House of Representatives

Dear Mr. Chairman:

In response to your request, this report provides information on the number of elderly who need long-term care, their access to this care, and the financing and delivery of long-term care in the United States.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Department of Health and Human Services and other interested parties.

The major contributors to this report are listed in appendix II.

Sincerely yours,

Janet L. Shikles

Janet L. Shikles
Associate Director

Executive Summary

Purpose

Advances in living conditions and medical care have enabled more Americans to live longer than ever before. But old age can be accompanied by chronic health problems, such as heart disease and arthritis. The elderly—those aged 65 and over—with these problems are frequently dependent on others to help them with everyday activities. Providing this help can impose a substantial burden on the elderly, their families, and the public sector.

Concerned about this situation, the Congress established the U.S. Bipartisan Commission on Comprehensive Health Care as part of the Medicare Catastrophic Coverage Act of 1988. Among other matters, the Commission is to make recommendations to the Congress about comprehensive long-term care services to the elderly. The Chairman of the Subcommittee on Health and Long-Term Care, House Select Committee on Aging, asked GAO to assist the Commission by providing information on (1) the number of elderly estimated to need long-term care now and in the next century, (2) the types of available long-term care services and access to them, and (3) public and private expenditures to finance and deliver long-term care.

Background

Long-term care refers to the array of medical, social, and support services for individuals in nursing homes or in the community who, for an extended period of time, are dependent on others for physical assistance. Surveys measuring the need for such care focus on people needing help with the (1) activities of daily living (ADLs) and (2) instrumental activities of daily living (IADLs). The ADL index measures a person's ability to independently carry out six basic functions of daily living, including feeding, toileting, and dressing. The IADL index measures the ability to carry out household activities, such as preparing meals, and mobility activities, such as getting around outside.

For this review, GAO examined an extensive body of research and conferred with experts on long-term care from the academic and health care communities, as well as officials in federal and state agencies who have responsibilities for managing long-term care programs.

Results in Brief

An estimated 6.2 to 6.5 million elderly were dependent on others in carrying out ADLs or IADLs or both in 1985. About one-fifth lived in nursing homes; the rest, in the community. Projections indicate that by the year 2020, the total number of dependent elderly may reach about 14.3 million.

Most of the care that the dependent elderly living in the community received came from unpaid (informal) sources; only about 5 percent relied totally on paid (formal) services. However, according to one survey, about 40 percent of the dependent elderly in the community did not get all the help they needed in carrying out ADLs and IADLs. For some, services may not be available, such as for the very dependent who may wait for a nursing home bed. Others may not receive care because public programs are not designed to cover long-term care needs or provide only limited coverage. A higher proportion of the elderly may have unmet needs in the future because obtaining informal care will become more difficult. Those who can afford to will have to pay for care.

Total expenditures for long-term care in fiscal year 1985 were $45 billion (primarily for nursing home care), almost evenly divided between public programs and private sources. Because of limited private insurance, private financing of long-term care is predominantly through out-of-pocket payments by the elderly and their families. High out-of-pocket costs can impoverish some elderly.

GAO's Analysis

Number of Dependent Elderly—6.2 to 6.5 Million

In 1985, of the 28.6 million elderly, an estimated 6.2 to 6.5 million depended on others for help with ADLs or IADLs or both. About 20 percent of these dependent elderly lived in nursing homes. The majority of dependent elderly, however, lived in the community. Projections indicate that the dependent elderly population could increase to about 14.3 million by 2020. Because researchers do not use the same ADL and IADL measures, estimates of the number of dependent elderly vary, especially the number of very dependent elderly.

Most Dependent Elderly Receive Informal Care

Nearly all of the elderly in the community received all or some of their care from informal caregivers—family and friends. However, at the same time that the number of dependent elderly is projected to increase, the portion of this population able to obtain informal care is likely to decrease; this is because of several societal trends, such as an increase in the proportion of women working outside the home. Thus, a higher proportion of the elderly may need to purchase formal care, but some may not be able to afford this care.

Many Dependent Elderly Have Unmet Needs

Despite help from family and friends, about 40 percent of the elderly with one or more ADL dependencies, in a 1982 survey, still had unmet needs for help with ADLs and IADLs. The more dependent the elderly were, the more likely they had unmet needs.

Getting Formal Care Is Sometimes a Problem

Some dependent elderly—who need formal care from a nursing home or from service providers that are home and community-based—have to wait to obtain such care. In some states, high nursing home occupancy rates and a limited supply of beds may cause some dependent elderly to wait for a bed. Individuals likely to wait the longest are those (1) with mental/behavioral problems or multiple ADL dependencies or both that require extra nursing care and (2) for whom payments will be made by Medicaid. The dependent elderly in the community also face difficulties in getting home and community-based care.

In addition, the dependent elderly find that public programs are either not designed to cover their long-term care needs in the community or provide only limited coverage. For example, Medicare, the federal health insurance program for the elderly and disabled, primarily covers acute care and is not intended to provide coverage for the long-term care needs of the dependent elderly. Although Medicaid, a federal grant program providing state medical assistance to the needy, funds about 50 percent of the nation's nursing home care, it funds only about 12 percent of home health care.

Most Expenditures Are for Nursing Home Care

The majority of public and private expenditures are for nursing home care; in fiscal year 1985, almost $36 billion of the estimated $45 billion spent nationally for long-term care was for nursing home care; $9 billion was spent on home health care for the dependent in the community.

Medicaid is the major public payer for nursing home care. In 1985, Medicaid accounted for $17.2 billion (90 percent) of public expenditures for nursing home care; Medicare paid less than 2 percent. Alternatively, Medicare plays a greater role in paying public expenditures for home health care, just over half—$2.3 billion—of home health care expenditures in 1985.

High Out-Of-Pocket Payments

Out-of-pocket payments by individuals and their families were an estimated $20 billion in 1985. These costs can be devastating for the elderly. For example, a long nursing home stay averages about $25,000 a year;

payments can exhaust people's assets and cause them to seek assistance from Medicaid. During the remainder of their lifetime, about 13 percent of 65-year-olds are likely to spend 1 year or longer in a nursing home.

Testing Alternative Delivery Approaches

Since the early 1970's, the federal government has sponsored demonstration efforts to test whether the substitution of home and community-based services for nursing home care would reduce costs and improve quality of life for the participants. These demonstrations generally showed that such substitutions increased the quality of life for participants, but also increased costs. Several national demonstration projects to test other new delivery approaches were authorized in 1986.

Private Sector Approaches Not Widely Used

Private financing mechanisms have been promoted as a way for the elderly and their families to use their resources to cope with rising long-term care costs. But these are not widely used. For example, less than 2 percent of the elderly have long-term care insurance. The high cost of premiums is one factor discouraging more widespread use.

Recommendations

GAO did not make any recommendations in this report.

Agency Comments

GAO did not obtain agency comments on this report.

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Abbreviations

ADL	activity of daily living
CBO	Congressional Budget Office
CRS	Congressional Research Service
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
IADL	instrumental activity of daily living
OTA	Office of Technology Assessment
S/HMO	social health maintenance organization
SSI	Supplemental Security Income
VA	Veterans Administration

Chapter 1

Introduction

Concerns about the adequacy of delivering and financing long-term care to meet the current and future needs of the elderly population led the Chairman of the Subcommittee on Health and Long-Term Care, House Select Committee on Aging, to request that GAO provide an overview of long-term care issues as they relate to the elderly. This overview is for the use of the U.S. Bipartisan Commission on Comprehensive Health Care, created to examine ways of improving the delivery and financing of health care in the United States.

Long-term care refers to the array of medical, social, and support services needed by individuals who, because of chronic illness or disability, need another person's help in caring for themselves over an extended period of time. Long-term care services are offered in varied settings, ranging from institutions such as nursing homes to an individual's own home. In this report, we review three long-term care issues: (1) the number of elderly in need of long-term care services, (2) the availability of these services, and (3) the financing and delivery of these services.

Background

Advances in living conditions and medical care have enabled more Americans to live longer than ever before. According to the U.S. Bureau of the Census, in 1987, 29.8 million Americans—about one in eight—were 65 and older. By 2020, it is projected that the elderly population will reach 51.4 million—about one in five Americans.

Individuals who are 85 years of age and over represent the fastest-growing segment of the elderly population, those 65 years of age and older. Between 1960 and 1980, the percentage of elderly 85 years of age and over rose from 5.6 percent to 8.8 percent; it is expected to increase to 14.7 percent by the year 2000. The number of those 85 years of age and over, often called the old old, has been increasing at a greater rate than those 65 to 74 years of age.

The growth in the elderly population has a particular significance for long-term care. This is because old age is often accompanied by the development of chronic health problems, such as heart disease, arthritis, and other ailments. These problems, important causes of disability among the elderly population, often result in the need for extensive long-term care services. This is especially true for those individuals 85 years of age and over, given that chronic conditions resulting in dependencies increase with age. Over 50 percent of those over 85 years of age are in need of care compared with about 13 percent of those 65 to 69 years of age.

Currently, public programs and private health insurance policies do not provide comprehensive coverage of the long-term care services the elderly may need. This is in contrast to existing private health insurance and public programs that pay for or provide coverage for acute health care services, such as hospital and doctor visits. Instead, most private health insurance has limited long-term care benefits that are often available only in conjunction with a hospital stay. Similarly, public programs do not comprehensively address long-term care needs.

Medicare is a major public health insurance program for the elderly and disabled. Enacted in 1965, under title XVIII of the Social Security Act, this program makes coverage available to insured individuals without regard to their income or assets. Though many elderly assume that Medicare will pay for a substantial portion of their long-term care expenses, Medicare expenditures are primarily for coverage of costs resulting from short-term acute illness; Medicare is not intended to pay for services for the long-term needs of the dependent elderly. In fiscal year 1987, Medicare payments for home health and nursing home care, for example, made up only about 5 percent of total program outlays of $79.5 billion. Because most elderly are unaware of their lack of protection, they are unprepared for long-term care expenses and must pay them out of pocket, sometimes exhausting their resources.

Medicaid is the other major public health program affecting elderly Americans. Enacted under title XIX of the Social Security Act, it is a federal and state program that provides assistance to certain categories of low-income people. Medicaid eligibility requirements vary by state, and qualifying for the program can be a function of an individual's assets and income. Medicaid has become the major public program that pays for nursing home care because it covers long-term custodial care. But some elderly are not eligible under the program when they enter a nursing home. Because of the high cost of nursing home care, they may exhaust their life savings and, thereby, become eligible for Medicaid. In 1987, Medicaid paid $17.2 billion for nursing home care.

Concern over the state of long-term care in the United States has been expressed by the Congress in hearings and proposed legislation related to such issues as (1) the financing of the catastrophic health care needs of the elderly, (2) the availability and access to care and the extent of coverage of long-term care needs by current programs, and (3) the quality of care received. During the past year, for example, legislation was passed that changed the regulation of nursing home care under Medicaid and Medicare and expanded benefits for health care services, including

some long-term care services. The effects of this recent legislation—primarily the Medicare Catastrophic Coverage Act of 1988 and provisions for nursing home quality in the Omnibus Budget Reconciliation Act of 1987—will not be known for several years.

By September 1988, more than 90 different legislative proposals addressing long-term care issues had been submitted for review in the 100th Congress. In addition, the Congress established the U.S. Bipartisan Commission on Comprehensive Health Care as part of the Medicare Catastrophic Coverage Act of 1988. The Commission is charged with two major tasks:

- Examine shortcomings in current health care delivery and financing mechanisms that limit or prevent access to comprehensive health care for all individuals in the United States.
- Make specific recommendations to the Congress about federal programs, policies, and financing needed to assure the availability of (1) comprehensive long-term care services for the elderly and disabled, (2) comprehensive health care services for the elderly and disabled, and (3) comprehensive health care services for all individuals in the United States.

The Commission is to deliver two reports to the Congress: a report and recommendations on long-term care for the elderly and the disabled and a report on health care for all Americans.

Objectives, Scope, and Methodology

The Chairman of the Subcommittee on Health and Long-Term Care, House Select Committee on Aging, requested that GAO assist the Commission by providing information on how long-term care is currently provided in the United States. More specifically, GAO agreed to provide an overview of the following issues as they relate to long-term care and the elderly:

- estimates of the number of elderly in need of long-term care now and in the next century,
- types of available long-term care and concerns about access to them, and
- public and private expenditures to finance and deliver long-term care.

In gathering material for this overview, we identified studies and other research material through bibliographic data bases, reference lists, and discussions with long-term care experts and federal and state officials who have responsibilities for managing programs involving long-term

care issues. We reviewed, synthesized, and analyzed information from existing studies, reports, congressional hearings, periodicals, and books (a bibliography of selected research literature related to long-term care is included). In addition, we conferred with experts on long-term care from the academic and health communities. We also convened a panel of experts to review and comment on a draft of this report.

Long-Term Care Needs of the Elderly

By evaluating a person's dependence on others for assistance with everyday activities such as cooking, cleaning, dressing, and bathing, long-term care needs can be determined. Using this evaluation, it is estimated that 6.2 to 6.5 million of the 28.6 million elderly in 1985 had some form of long-term care need, ranging from help with ordinary household tasks to help with all everyday activities.

About one in five of the dependent elderly lived in nursing homes in 1985. Approximately half of these nursing home residents were very dependent and needed help with almost all activities. In contrast, an estimated 4.9 to 5.2 million dependent elderly, two-thirds of whom were women, lived in their own homes or with others in the community. Between 621,000 and 955,000 of those in the community were estimated to be very dependent.

The dependent elderly living in the community primarily rely on unpaid (informal) care from family, such as wives and adult daughters, and friends. Whether the dependent elderly will be able to rely as heavily on informal care in the future is, however, unclear. Projections indicate that the elderly population needing long-term care could increase to about 14.3 million in 2020. Social and demographic trends are likely to result in reduced availability of caregivers. Consequently, in the future, the dependent elderly may need to rely more heavily on paid (formal) services. But they may not have the resources to purchase the care they need.

How Are Long-Term Care Needs Evaluated?

Long-term care needs are often evaluated by measuring a person's dependence on others for help with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Such dependence can be caused by health problems of a chronic nature, such as arthritis and heart conditions.

Surveys of the nursing home population and the elderly in the community use similar measures of ADL dependency. The 1985 National Nursing Home Survey, conducted by HHS's National Center for Health Statistics, obtained information about nursing home residents' ability to independently carry out six basic functions of daily living: (1) bathing, (2) dressing, (3) using the toilet, (4) getting in or out of a bed or chair, (5) continence (bowel or bladder control or both), and (6) eating. The 1982 National Long-Term Care Survey, conducted by the Bureau of the Census at HHS's request, obtained information about the long-term care

needs of the elderly in the community. This survey identified dependencies in the same ADLs as the National Nursing Home Survey, but excluded continence and included getting around inside the house. As the number of ADL dependencies increases, a person is considered more dependent. A person with five or six ADL dependencies is considered to be very dependent.

The National Long-Term Care Survey also identified dependencies in IADLs that measure the ability to carry out household and mobility activities. These dependencies cause a person to have problems with (1) preparing meals, (2) doing laundry, (3) doing heavy work, (4) grocery shopping, (5) managing money, (6) taking medicine, (7) making telephone calls, (8) doing light work, (9) getting around outside, and (10) going places beyond walking distance. Dependencies in IADLs are considered less serious than dependencies in ADLs. Because IADLs measure ability to manage in the community, they are not used for nursing home residents; the nursing home either helps the resident with an IADL dependency or eliminates the need for the IADL.[1]

Because the National Nursing Home Survey and the National Long-Term Care Survey do not use the same measures, their results are not entirely comparable. Researchers have also used different ADL and IADL measures to analyze the results of the National Long-Term Care Survey. For example, one analysis used 7 rather than 6 ADLs; that analysis included continence problems as an ADL.[2] Another analysis used 7 of the 10 IADLs.[3] As a result, analyses differ on the number of dependent elderly in the community, particularly with respect to the level of dependency.

In some cases, the level of dependency changes over time. According to a recent analysis of the 1982 and 1984 National Long-Term Care Surveys, over a 2-year period, 22 percent of those with five or six ADL dependencies and 24 percent of those with dependencies in two or three ADLs

[1]ADL and IADL measures do not fully capture the need for help experienced by people who are cognitively dependent because of dementia in addition to being physically dependent. For example, individuals with dementia may be physically capable of getting dressed, but lack judgment about what to put on and when to do so. The tendency for such individuals to try to carry out certain activities that they are no longer capable of doing safely or effectively is not included on most instruments measuring competence in ADLs or IADLs.

[2]C. Macken, "A Profile of Functionally Impaired Elderly Persons Living in the Community," Health Care Financing Review, Vol. 7 (Summer 1986), pp. 33-49.

[3]K. Liu, K. Manton, and B. Liu, "Home Care Expenses for the Disabled Elderly," Health Care Financing Review, Vol. 7 (Winter 1985), pp. 51-57.

showed a decrease in the number of ADL dependencies; the rest stayed at the same level, got worse, or died.[4]

What Are the Elderly's Current Long-Term Care Needs?

Based on surveys of the elderly, it was estimated that in 1985, between 6.2-6.5 million of the 28.6 million elderly had some type of long-term care need. About 20 percent of these people were in nursing homes and 80 percent in the community;[5] their levels of dependency varied. An estimated 1.6 to 1.8 million elderly required help in only IADLs, such as shopping. At the other end of the range of need, an estimated 1.3 to 1.6 million elderly were very dependent, needing help with almost all ADLs. The need for help tended to increase with age.

Twenty Percent of Dependent Elderly Lived in Nursing Homes

About 20 percent (1.3 million) of the dependent elderly lived in nursing homes in 1985. As shown in table 2.1, about 92 percent (1.2 million) of these elderly nursing home residents had one or more ADL dependencies; approximately half were very dependent, with five or six ADL dependencies.

Table 2.1: Dependency Level of Elderly in Nursing Homes (1985)

Figures in thousands

ADL dependency level	Number	Percent
No ADLs	100[a]	8
1 to 2 ADLs	275[a]	21
3 to 4 ADLs	282[a]	21
5 to 6 ADLs	664[a]	50
Total	**1,321**	**100**

[a]Adjusted to reflect latest Census Bureau estimates for the elderly population in 1985.

Source: GAO calculations based on E. Hing, "Use of Nursing Homes by the Elderly: Preliminary Data from the 1985 National Nursing Home Survey," Advance Data, No. 135 (National Center for Health Statistics, May 14, 1987).

[4]K. Manton, "Planning Long-Term Care for Heterogeneous Older Populations," Annual Review of Gerontology and Geriatrics (Springer Publishing, forthcoming).

[5]GAO calculations in this section are based on data from the 1985 National Nursing Home Survey by E. Hing, "Use of Nursing Homes by the Elderly: Preliminary Data from the 1985 National Nursing Home Survey," Advance Data, No. 135 (National Center for Health Statistics, May 14, 1987); and the 1982 National Long-Term Care Survey by (1) K. Manton and K. Liu, "The Future Growth of the Long-Term Care Population: Projections Based on the 1977 National Nursing Home Survey and 1982 [National] Long-Term Care Survey," prepared for presentation at the Third National Leadership Conference on Long-Term Care Issues (Washington, D.C., March 7-9, 1984); (2) Liu, Manton, and Liu, "Home Care Expenses for the Disabled Elderly," pp. 51-57; and (3) Macken, "A Profile of Functionally Impaired Elderly Persons Living in the Community," pp. 33-49. We used data from the 1982 National Long-Term Care Survey because there have been only limited analyses of the results of the 1984 National Long-Term Care Survey.

Elderly nursing home residents tended to be female (75 percent); in addition, about 45 percent were aged 85 and over. The likelihood of living in a nursing home increases with age. Only 1.3 percent of those aged 65 to 74 are in nursing homes compared with 5.8 percent of those aged 75 to 84 and 21.9 percent of those aged 85 and older.[6]

Nursing homes serve more of the very dependent elderly than they did in the mid-1970's. Analysis of the 1985 National Nursing Home Survey found that, in general, elderly nursing home residents had more ADL dependencies in 1985 than in 1977. In 1985, a larger proportion of residents, compared with 1977, required help or had difficulty with bathing, using the toilet, continence, and eating. This greater proportion of dependent elderly can be explained, in part, by the increasing number of old old people (85 years of age or over) in nursing homes. Some also attribute the change in the ADL profile to (1) the increased availability of community care in the 1980's and (2) state efforts to provide more thorough screening of elderly applicants before approving Medicaid funding for nursing home care.

Individuals who have not only physical impairments but also cognitive impairments, such as those caused by Alzheimer's disease, represent a significant proportion of nursing home residents. In 1985, 47 percent of elderly nursing home residents were disoriented or memory-impaired.[7]

Most Dependent Elderly Received Long-Term Care in the Community

In 1985, 80 percent of the dependent elderly, an estimated 4.9 to 5.2 million dependent elderly, lived at home, in the community (see table 2.2). The majority were women, outnumbering men two to one. About 3.4 to 3.5 million of these elderly had one or more ADL dependencies and an estimated 621,000 to 955,000 were severely disabled, with five or more ADL dependencies.

Because of different definitions of dependency, estimates of the total number of dependent elderly in the community vary, especially the number of very dependent elderly. A range of estimates for the dependency level among the dependent elderly in the community is shown in table 2.2.

[6]Hing, "Use of Nursing Homes," p. 2.

[7]Hing "Use of Nursing Homes," p. 6.

Table 2.2: Range of Estimates for the Dependency Level of Elderly in the Community (1985)

Figures in thousands

ADL and IADL dependency level	Number		Percent	
	Low	High	Low	High
IADLs only	1,525	1,736	31	33
1 to 2 ADLs	1,679	1,961	34	38
3 to 4 ADLs	762	897	15	17
5 or more ADLs	621	955	12	19
Total	**4,911[a]**	**5,216[a]**		

[a]The estimates for each dependency level do not add to the totals, which represent the lowest and highest overall estimates. Estimates for each dependency level are the lowest and highest.

Source: GAO calculations used data in K. Manton and K. Liu, "The Future Growth of the Long-Term Care Population: Projections Based on the 1977 National Nursing Home Survey and 1982 [National] Long-Term Care Survey," prepared for presentation at the Third National Leadership Conference on Long-Term Care Issues (Washington, D.C., March 7-9, 1984); K. Liu, K. Manton, and B. Liu, "Home Care Expenses for the Disabled Elderly," Health Care Financing Review, Vol. 7 (Winter 1985); and C. Macken, "A Profile of Functionally Impaired Elderly Persons Living in the Community," Health Care Financing Review, Vol. 7 (Summer 1986).

Of the dependent elderly in the community receiving care, most received all their care from informal caregivers, who provided support ranging from transportation to 24-hour supervision. Only about 5 percent of the dependent elderly received all their care through formal services.[8] In a 1982 survey of caregivers providing informal care, women were found to make up 72 percent of the caregivers, with adult daughters accounting for 29 percent and wives 23 percent. Husbands made up 13 percent of informal caregivers; the other informal caregivers included sons, daughters-in-law and sons-in-law, grandchildren, brothers or sisters, and other relatives and friends.[9]

Since wives generally outlive their husbands, the person providing care differs for men and women. For an elderly man, the primary caregiver is most often a wife, followed by adult children, other relatives, and formal service providers. For an elderly woman, the primary caregiver is usually an adult child, followed by relatives, a husband, and formal service providers.[10]

[8]Liu, Manton, and Liu, "Home Care Expenses for the Disabled Elderly," p. 52.

[9]R. Stone and others, "Caregivers of the Frail Elderly: A National Profile," The Gerontologist, Vol. 27 (1987), pp. 616-26.

[10]U.S. Senate Special Committee on Aging, Developments in Aging: 1987, Vol. 3, The Long-Term Care Challenge (Washington, D.C.: U.S. Government Printing Office, 1988), pp. 20-22.

Dependent Elderly of the Future May Increasingly Rely on Formal Services

Because of the projected aging of the U.S. population and greater life expectancy at advanced ages, the elderly long-term care population is expected to increase from an estimated 6.2 to 6.5 million in 1985 to about 14.3 million in 2020. The nursing home population is expected to increase to about 4.2 million; the number of dependent elderly in the community is expected to increase to 10.1 million. The most rapidly growing segment of the disabled elderly in the community is the very dependent, those with five or more ADL dependencies.[11,12] Other definitions of disability could be used to produce somewhat different estimates.[13]

At the same time that the dependent elderly population is projected to increase, the portion of the elderly population able to obtain unpaid care in the future is likely to decrease. Several societal trends (the number of women working outside the home, family members living far apart, high divorce rates, and smaller families) could have an impact on the availability of informal caregivers. Although the parents of the Baby Boom generation will have a relatively greater number of children available to care for them, the increased participation rate of women in the labor force may mean there will be fewer daughters at home to provide care. For women between 45 and 54 years of age, 60 percent were in the labor force in 1980 and 70 percent are projected to be in 1995. For women

[11]K. Manton, "Epidemiological, Demographic, and Social Correlates of Disability Among the Elderly," prepared for the Milbank Fund Quarterly/Health and Society Supplement on Disability, Vol. 67 (1989), and presented at the Milbank Roundtable on Disability Policy (Harriman, N.Y., Sept. 23-24, 1988).

[12]Estimates were derived from the 1985 National Nursing Home Survey and the 1984 National Long-Term Care Survey and assume constant age, sex, and marital status-specific disability rates. These are updates and extensions of projections prepared in 1984, based on the 1977 National Nursing Home Survey and the 1982 National Long-Term Care Survey. At that time, it was estimated that the long-term care population in 2020 would be 12.9 million, including 2.8 million elderly in nursing homes and 10.1 million in the community (Manton and Liu, 1984). The upward revisions to the projections are due partly to (1) the growth of the 85 years of age and older population, with their much higher risks of disability and institutionalization, and (2) a higher proportion of 1984 National Long-Term Care Survey respondents reporting IADL dependencies than in the 1982 survey.

[13]The number of nonelderly requiring long-term care is also projected to increase. This group includes the chronically mentally ill, disabled adults (such as those suffering from a chronic disabling disease or physically disabled from accidents), and the developmentally disabled (including the mentally retarded). Moreover, medical technology is prolonging the lives of many younger people suffering chronic, degenerative illnesses and trauma-related injuries; this places additional demands on the resources available for dealing with long-term care needs. Finally, those with acquired immune deficiency syndrome (AIDS) may make increasing demands on the long-term care system. Since the elderly are the focus of this report, we did not pursue specific projections of long-term care needs for these groups.

between 35 and 44 years of age, 66 percent were in the labor force in 1980 and 83 percent are projected to be in 1995.[14]

Another possible trend that could increase the demand for formal services is the growing proportion of elderly who live alone; these elderly may be more likely to face problems in receiving the care necessary to maintain themselves in the community if they become dependent. Between 1960 and 1984, the proportion of elderly living alone increased from 18.6 percent to 30.6 percent. This proportion may increase to as high as 38 percent by 2030, according to some projections.[15]

Given these trends, a higher proportion of the elderly may need to purchase formal services. Although some will be able to pay, others will not. The elderly's economic status is determined, in large part, by their past involvement in the work force, the amount of assets they have accumulated, their private pension coverage, and whether they own their own homes and how much these homes are worth.

Because of higher pensions and increases in income from assets and Social Security benefits, median family income of the young old (aged 65 to 74), estimated to be about $11,000 in 1987 dollars during 1986-90, will more than double to $23,000 in 1987 dollars by 2016-20. Median family assets will increase from about $68,000 to over $94,000 in 1987 dollars during this period. But median family income of the old old (aged 85 and over), who are most likely to need and use formal long-term care services, will only increase about 17 percent during the next three decades—from under $7,000 to about $8,000; the assets of these elderly will increase from a median value of about $40,000 to more than $56,000. Long-term care costs, however, are projected to rise faster than the income of this future old old group. It appears, therefore, that those most likely to need care in 2020 may have greater difficulty purchasing the services they need.[16]

[14]U.S. Department of Labor, Bureau of Labor Statistics, "Employment Projections for 1995," Bulletin 2197 (March 1984), p. 3.

[15]Congressional Budget Office, Changes in the Living Arrangements of the Elderly: 1960-2030 (March 1988), pp. 3 and 52-59.

[16]A. Rivlin and J. Wiener, Caring for the Disabled Elderly, Who Will Pay? (Washington, D.C.: The Brookings Institution, 1988), pp. 10-12.

Concerns About Access to Long-Term Care Services

The future elderly may have to rely more on formal long-term care services as the availability of informal caregivers declines. Currently, some needs of the dependent elderly—especially the very dependent—are not met, partly because formal services may not be available.

Some of the very dependent elderly may not be able to gain access to long-term care facilities in states with high nursing home occupancy rates. In addition, state variation in nursing home bed supply may mean that there is a greater likelihood of unmet needs for care in states with fewer beds per 1,000 elderly. Finally, despite extensive support by family and friends, an elderly person with five or more ADL dependencies who is in the community is most likely to have unmet needs. For these elderly, public programs currently are either not designed to cover their needs for care outside a nursing home or provide only limited coverage.

Very Dependent Elderly Require Extensive Help

Among the long-term care population, a person requiring the greatest amount of help, sometimes several times a day, is one with five or more ADL dependencies; such a person is unable to function independently. Without continuous attention by another person, as well as help with ADLs (such as eating), a very dependent elderly person may face a life-threatening situation.

The very dependent elderly live in both nursing homes and the community. (As noted in the previous chapter, in 1985 about half of the more than 1.3 million elderly nursing home residents were very dependent, with five or more ADL dependencies. In addition, between 621,000 and 955,000 elderly in the community were very dependent.) The very dependent elderly, however, have more difficulty obtaining nursing home care and are more likely not to have their care needs met in the community.

Problems in Obtaining Access to Long-Term Care Facilities

The dependent elderly are admitted to nursing homes for a variety of reasons.[1] Most studies have found that factors associated with a greater probability of nursing home admission include age, diagnostic condition, ADL dependencies, living alone, marital status, mental status, race, lack of social support, and income.[2] Some individuals go into nursing homes requiring rehabilitative care of a short duration as a result of an acute illness; other individuals are severely dependent and require extensive care for months or years.

The Role of Medicaid and Medicare

The Medicaid program plays a key role in support of nursing home care. The 1985 National Nursing Home Survey showed that at the time of admission, Medicaid was the primary source of payment for 40.1 percent of elderly nursing home residents. Almost 50 percent of elderly nursing home residents relied primarily on their own income or family support to pay for the first month in the nursing home.

Medicare covers nursing home care if the patient requires skilled nursing or physical therapy on a daily basis. Such benefits have been limited to 100 days following a hospital stay of at least 3 days. The Medicare Catastrophic Coverage Act of 1988 extends coverage to 150 days a year, beginning in January 1989, but still limits coverage to people requiring daily skilled nursing care (see app. I). Despite this provision, some people who require long-term nursing home care do not need daily skilled nursing care and, therefore, do not qualify for the Medicare benefit. The 1985 National Nursing Home Survey found that at the time of admission, only 4.9 percent of elderly residents relied on Medicare to cover the costs of their care.[3,4]

[1]The 1985 National Nursing Home Survey reported an estimated 19,100 nursing homes in the United States. According to a HCFA official, there were 14,993 certified nursing home in 1987.

[2]R. Kane and R. Kane, Long-Term Care: Principles, Programs, and Policies (Springer Publishing Company, 1987), p. 31. This provides analysis of 13 studies of risk factors predicting institutionalization of the elderly.

[3]E. Hing, "Use of Nursing Homes by the Elderly: Preliminary Data From the 1985 National Nursing Home Survey," Advance Data, No. 135 (National Center for Health Statistics, May 14, 1987).

[4]The Veterans Administration (VA) also provides support for nursing home care. In fiscal year 1987, nursing home care units in VA medical centers treated nearly 26,000 veterans. In addition, nearly 42,500 veterans received care through VA's community nursing home program.

Very Dependent Elderly Have More Difficulty Obtaining Nursing Home Care

States vary significantly in the number of nursing home beds available per 1,000 elderly. The average supply of Medicaid-certified nursing home beds nationwide, in 1985, was about 125 beds per 1,000 persons over 75 years of age, but the supply ranged from approximately 202 beds per 1,000 in Minnesota to about 60 beds per 1,000 in Florida.[5] Such variation in supply affects the use of nursing homes by the elderly. On the basis of a study examining nursing home utilization by a group of elderly with similar characteristics (very dependent, one or more high risk diagnoses, unmarried, low-income status, and over 75 years of age), it was concluded that there is a greater likelihood that unmet needs for care exist in states with fewer beds per 1,000 elderly.[6]

In addition, nursing home beds are in tight supply, with an average 91 percent occupancy rate in 1988.[7] However, occupancy rates vary across states. Data from the Health Care Financing Administration (HCFA) indicate that as of October 1988, occupancy rates for Medicaid-certified and Medicare-certified nursing homes ranged from 81 percent in Utah to 98 percent in Mississippi; 42 states had an occupancy rate equal to or greater than 90 percent; 10 states had an occupancy rate equal to or greater than 95 percent.

Not all dependent elderly who enter nursing homes require the same level of care. Some require special, labor-intensive nursing care, such as tube-feeding, as well as other assistance with ADLs. Those patients who require these services are expensive to take care of and are termed heavy-care patients. Light-care patients, on the other hand, are the elderly with less complex or costly care needs.

One effect of a shortage of nursing home beds is that some nursing homes may choose the patients that are more profitable—such as private-pay patients (who pay higher rates) or those Medicaid patients who have relatively limited care needs. Past research has shown that those most likely to have to wait for nursing home placement are those

[5]E. Neuschler and C. Gill, Medicaid Eligibility for the Elderly in Need of Long-Term Care, Report 87-986 (Congressional Research Service, Sept. 1987), pp. 24-25.

[6]W. Weissert and W. Scanlon, "Determinants of Institutionalization of the Aged," Project to Analyze Existing Long-Term Care Data: Final Report, Vol. III (prepared under contract HHS-100-80-0158 with HHS Office of the Assistant Secretary of Health and Administration on Aging, 1983).

[7]According to health planning experts, an occupancy rate of 90 percent and over is an indicator of tight supply. One reason for the tight supply is due to actions taken by state governments to control the rate of increase in Medicaid nursing home expenditures, including regulating the nursing home bed supply or restricting reimbursement or both.

(1) with mental/behavioral problems, (2) with multiple ADL dependencies requiring extra nursing care, and (3) financed by Medicaid.[8] A more recent study concluded that heavy-care Medicare hospital patients are more likely to wait for nursing home placement when nursing home beds are in short supply.[9]

Nursing homes may favor light-care Medicaid patients because of (1) state efforts to limit reimbursements and (2) the lack of variation in rates according to patient care needs. Concern over this issue has led several states to adopt a payment approach (known as case-mix) that pays more for treating patients with more complex care needs. States using this approach are Illinois, Maryland, Minnesota, Montana, New York, Ohio, and West Virginia.

An evaluation of New York State's case-mix reimbursement system, known as the Resource Utilization Groups system, concluded that nursing homes were admitting more heavy-care patients than before the system was implemented. Between 1985 and the first half of 1986 (the New York State system became operational on January 1, 1986), the average case-mix index—a measure of service needs—increased 11.5 percent for new admissions. The study concluded that nursing homes appeared to be responding to the incentives to accept higher disability patients and specialized patient types (such as those requiring rehabilitation); for example, there was an increase in the average level of ADL dependencies for patients gaining access to nursing homes.[10]

Case-mix reimbursement usually requires new administrative functions, including assessing patients and incorporating patient assessments and reassessments into the rate-setting process. On the other hand, concerns have been raised over the use of the case-mix approach, including (1) its

[8]L. Gruenberg and D. Willemain, "Hospital Discharge Queues in Massachusetts," Medical Care, Vol. 20 (Feb. 1982), pp. 188-201.

[9]J. Holahan and L. Dubay, "The Effects of Nursing Home Bed Supply in Hospital Discharge Delays," Urban Institute Working Paper 3710-01-01 (May 1988).

[10]New York State Department of Health, "Initial Outcomes: Survey to Monitor Implementation of Case-Mix Reimbursement System" (Oct. 1986).

effects on the access of light-care patients to long-term care services and (2) the disincentive created for rehabilitating patients.[11]

SSI Program and Board and Care Homes

Board and care homes provide the dependent elderly person with a room, meals, help with ADLs such as dressing, bathing, and grooming, as well as some degree of protective oversight. A nationwide survey in 1987 reported a total of about 41,000 licensed homes with about 563,000 beds.[12] This represents an undercount of the number of beds and facilities because data are not available on the number of unlicensed homes in operation. In addition, in fiscal year 1987, the Veterans Administration (VA) treated a daily average of 11,400 veterans in its community residential care home program, utilizing approximately 2,900 homes.

There is some evidence that SSI recipients may face problems in gaining access to board and care homes. SSI recipients are aged, blind, or disabled individuals who receive monthly cash payments. In 1988, the federal benefit payment was $354 per month for an individual; in addition, most states provide additional income support through state supplements to SSI.[13]

Surveys have identified that the board and care population includes many residents with very limited income. One recent survey of more than 6,000 residents in New Jersey, for example, showed that about 45 percent were on SSI. Several state studies have shown that because the costs of operating board and care homes exceed available SSI benefits for residents, some homes were closing and others refusing to admit SSI

[11]HCFA, which supported the development of the Resource Utilization Groups system, continues to fund research on (1) reimbursement systems, including refinements of the New York State system, and (2) whether this system, developed on the basis of data from the New York nursing home population, can be applied to other states. In order to address these case-mix concerns, HCFA is undertaking major demonstrations. The purpose is to determine if a common classification system, which employs a standard assessment and analysis of services, can be used to develop service profiles and to assess quality from an outcome perspective. According to a HCFA official, it is also expected that the demonstrations will show which combinations of services are used and which combinations have a more positive effect on resident outcomes. Finally, the demonstrations are intended to assist in the development of national standards of care.

[12]National Association of Residential Care Facilities (NARCF), 1987 Directory of Residential Care Facilities (Richmond: NARCF, 1987), p. 5.

[13]Enacted in 1972 as title XVI of the Social Security Act and implemented in 1974, SSI was intended to provide a uniform minimum income to the needy throughout the nation. In 1988, an estimated 4.4 million individuals will receive SSI payments—1.45 million because they are 65 or older and 2.96 million because they are blind or disabled.

recipients, resulting in a shortage of beds for them. Limitations on current public subsidies may hinder continued operation and development of board and care homes, specifically for those elderly with limited financial resources who are, traditionally, dependent on SSI for support.

Unmet Care Needs of the Dependent Elderly in the Community

Not only do the very dependent elderly face problems in gaining access to nursing homes and board and care facilities, they may also find it difficult to obtain needed services in the home, even with help from family and friends.

As discussed in chapter 2, most of the dependent elderly who live at home, in the community, rely on spouses, children, or others to provide them with the services they need. On the basis of an analysis of the 1982 National Long-Term Care Survey, of those who received care, about 74 percent received all their care from family members or others; almost 21 percent used both formal and informal care, and about 5 percent used formal care exclusively.[14]

Family and friends who play a critical role in providing care to the dependent elderly do so at a significant cost. On an average day, caregivers assisting the elderly with ADLs spent approximately 4 hours on caregiver tasks, especially help with shopping and transportation. Four out of five caregivers helped with household tasks; two-thirds provided assistance with one or more personal hygiene ADLs, and 46 percent assisted with indoor mobility. In addition, one-half administered medication to the dependent person.[15]

Very Dependent Elderly More Likely to Have Unmet Needs

Despite the caregiving efforts of family and friends, the elderly with one or more ADL dependencies did not get all the help they needed. An analysis of data from the 1982 National Long-Term Care Survey showed that of an estimated 3.2 million elderly with one or more ADL dependencies, 168,000 (5 percent) were not receiving all of the help they needed with ADLs; an additional 1.1 million (34 percent) needed more help with IADLs.[16] Typically, unmet needs limited the dependent elderly's mobility,

[14]K. Liu, K. Manton, and B. Liu, "Home Care Expenses for the Disabled Elderly," Health Care Financing Review, Vol. 7 (Winter 1985), p. 52.

[15]R. Stone and others, "Caregivers of the Frail Elderly: A National Profile," The Gerontologist, Vol. 127, No. 5 (1987), pp. 616-26.

[16]Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986), p. 50.

ranging from getting in and out of bed to getting around outside the home.

The more dependent the elderly were, the greater the likelihood that they had unmet needs (see table 3.1). Most of the long-term care population is comprised of older women, as discussed in chapter 2, and a high percentage of those dependent elderly with unmet needs were women over 75 years old.

Table 3.1: Percent Distribution of the Elderly With Met and Unmet Needs by ADLs and IADLs

	ADLs and IADLs for which help is needed			
	1-2	3-4	5-6	Total
ADLs and IADLs met	55.8	22.6	21.6	100
Unmet IADLs only	47.3	20.6	32.1	100
Unmet ADLs[a]	29.5	22.0	48.5	100

[a]Includes people who may also have unmet IADL needs.

Source: 1982 National Long-Term Care Survey.

Some needs may not be met because home health and other in-home services may not be available. A GAO survey of hospital discharge planners reported inadequate availability of some services for patients following discharge. Most discharge planners reported that the percentage of patients waiting in the hospital for placement in post-hospital care was greater in 1985 than 1982. Of those surveyed, 29 percent responded that the supply of home health care was a barrier in providing care for Medicare patients awaiting discharge. The discharge planners generally said the availability of this care was adequate nationally except in the Northeast, but the supply of homemaker services was inadequate or only marginally adequate across the country.[17]

Medicare Not Designed to Cover Long-Term Care Needs

More of the dependent elderly receive informal care from family and friends rather than formal care perhaps because of the lack of support by public programs for long-term care services in the community.[18] Although Medicare is the largest public payer of home services for the elderly, its coverage of home health benefits is intended for treatment of

[17]Posthospital Care: Discharge Planners Report Increasing Difficulty in Placing Medicare Patients (GAO/PEMD-87-5BR, Jan. 23, 1987), p. 14.

[18]W. Scanlon and J. Feder, "The Long-Term Care Marketplace: An Overview," Healthcare Financial Management, Vol. 14 (Jan. 1984), p. 36.

acute care conditions and for post-acute care. Services specifically covered by Medicare include

- part-time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse;
- physical, occupational, and speech therapy;
- medical social services provided under the direction of a physician;
- medical supplies and equipment (other than drugs and medicines); and
- part-time or intermittent services provided by a home health aide when needed, in conjunction with skilled nursing care, physical therapy, or speech therapy.

Medicare currently pays for daily home health care visits, but only for a short period, usually limited to 2-3 weeks. The Medicare Catastrophic Coverage Act of 1988 extends this coverage to 38 consecutive days in 1990, but still limits coverage to acute care conditions (see app. I). In a new benefit added under the act, Medicare will pay for up to 80 hours a year for an outside aide to relieve family and friends who are taking care of a beneficiary. To qualify, individuals must have two or more ADL dependencies.

Even with the limitations on Medicare's coverage of home health care, it is one of the fastest-growing parts of the program. Medicare-certified home health agencies increased from 2,212 in 1972 to about 5,800 in 1988. In 1985, almost 1.6 million Medicare beneficiaries received home health care services at some time during the year; beneficiaries over 85 years of age were five times more likely to use these services than beneficiaries aged 65 to 69.

Medicaid Home and Community-Based Service Programs Not Widely Used

State participation in home and community-based services covered by Medicaid is not extensive. The current Medicaid statute provides states with the authority to include case management, personal care services, day care, private duty nursing, and home health services in their Medicaid programs. Some states, however, see these services as (1) potentially costly and difficult to manage and (2) not permitting targeting of services to address the specific long-term care needs of the elderly.[19] For example, a state cannot provide personal care services just to aged SSI recipients without also making these services available to those who are categorically eligible, such as the blind or the disabled, including the

[19]D. Justice and others, State Long Term Care Reform: Development of Community Care Systems in Six States (National Governors' Association, Apr. 1, 1988), p. 121.

mentally disabled. At present, this part of the Medicaid program is not used widely on a national level. For example, in fiscal year 1985, New York State accounted for about 62 percent of all Medicaid expenditures for home health care.

Medicaid also includes the section 2176 waiver (Home and Community-Based Waiver Program), which was established by the 1981 Omnibus Budget Reconciliation Act. This program allows a much wider potential range of home and community-based services, including nonmedical services. It covers case management, personal care, adult day care, home health care, homemaker, respite care, and other services. Although 42 states participate in the program, relatively few of the dependent elderly are currently served. The program limits its funding to those who would otherwise require Medicaid-financed nursing home care. HCFA does not have information on the number of elderly served under the program, but the National Governors' Association found that 59,000 elderly were being served by the program at the time of a survey conducted in mid-1987.

HHS has limited the growth of the program by using federal cost-control criteria, which were designed to ensure that the program costs do not increase overall Medicaid costs. Therefore, the total number of people served could increase, but not total expenditures. Recent legislation has changed these criteria; the combined costs of care will be allowed to increase in future years by a specified percentage. HHS is required to develop the percentage by October 1, 1989.

Other Public Programs Provide Limited Coverage

The Social Services Block Grant Program, VA, and title III of the Older Americans Act have limited resources that can be used to provide home and community-based services. Although national data are unavailable on the number of elderly recipients receiving long-term care through the block grant program, available data for VA and title III programs show that few elderly receive care through these programs when compared with the total number of dependent elderly in the community.

Through the block grant program, states may provide homemaker, home health aide, chore, adult day care, and adult foster care services. Because of limited federal reporting requirements, little national data are available on recipients of services. VA runs a hospital-based home care program and an adult day health care program. In fiscal year 1987,

over 13,350 veterans were served under the home care program. Veterans were also treated in 15 VA facilities, as part of the adult day health care program.

In-home care, including homemaker, chore, and home health aide services, is a major service category under title III of the Older Americans Act, established in 1965. According to the Administration on Aging, the estimated number of client contacts in 1987 ranged from 6.3 million for transportation to almost 1 million for homemaker and home health aide services.

The Older Americans Act Amendments of 1987 included an authorization of funds for nonmedical in-home services for the dependent elderly. The new provision covers homemaker and home health aides, visiting and telephone reassurance, chore maintenance, in-home respite care, and adult day care as respite for families. In this legislation, eligible elderly are defined as those with a physical or mental disability, including Alzheimer's disease, that (1) restricts their ability to carry out ADLs or IADLs or (2) threatens their capacity to live independently.

Chapter 4

Financing Long-Term Care Services

Financing long-term care services is a major problem for federal and state governments and for the elderly and their families. Nationally, $45 billion was spent on long-term care in 1985. These expenditures, almost evenly divided between public programs (52 percent) and private sources (48 percent), were primarily for nursing home care.

Medicaid is the major payer for nursing home care and, in 1985, it accounted for $17.2 billion (90 percent) of publicly funded nursing home care. In contrast, Medicare paid for less than 2 percent. Medicare plays a greater role, however, in underwriting home health care, paying for just over half[1] —$2.3 billion of a total $4.5 billion in 1985; Medicaid paid for $1.1 billion.

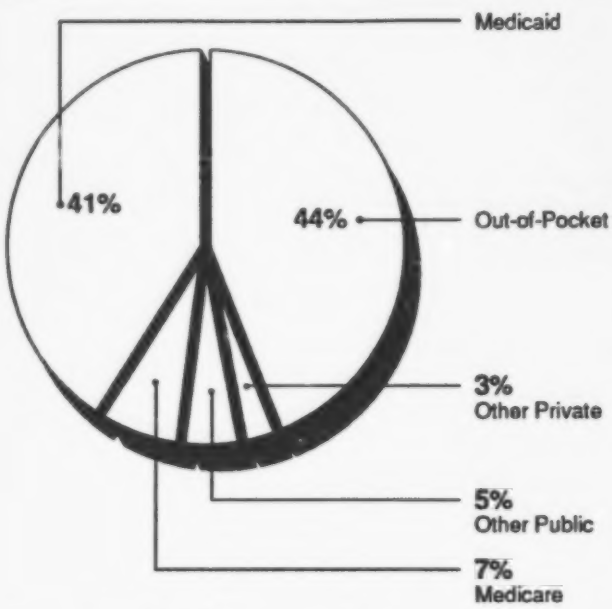
Private financing of long-term care is predominantly through out-of-pocket payments by the elderly and their families. Such out-of-pocket payments can be personally devastating for those in need of extensive care, such as a long stay in a nursing home. In addition, these out-of-pocket payments are increasing at a faster rate than public expenditures.

Spending for Long-Term Care: An Estimated $45 Billion

In fiscal year 1985, an estimated $45 billion was spent nationally for long-term care. About half of this amount was borne by public programs, primarily Medicaid (41 percent), followed by Medicare (7 percent); the other half, predominantly by patients and their families (see fig. 4.1). In 1985, federal, state, and local government expenditures were about $23.5 billion (52 percent) for long-term care services; private expenditures, about $21.3 billion (48 percent).

[1] Although certain social services, such as home management and delivery of meals, can be included in the definition of long-term care, spending for these services is not reflected in the estimates presented here.

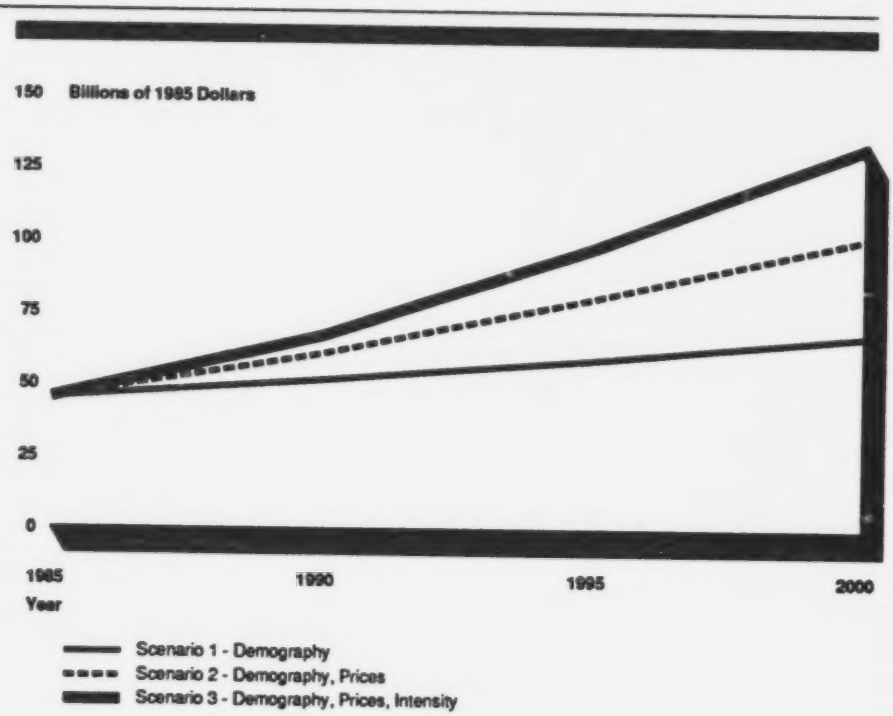
Figure 4.1: Distribution of Long-Term Care Expenditures (Fiscal Year 1985)



Source: Congressional Budget Office, 1987

The Congressional Budget Office (CBO) has projected that long-term care expenditures could increase between 50 percent and 200 percent from 1985 to 2000. Three different scenarios were used for these cost projections: The first scenario projects a 50 percent increase in long-term care spending—to about $67 billion in 1985 dollars—during 1985 to 2000; the growth of the elderly population is the only factor considered as affecting spending. The second scenario projects that spending will more than double—adding as a factor the 1975-84 trend of escalating medical costs—to about $101 billion in 1985 dollars by the year 2000. The final scenario projects spending to triple—adding as a factor the 1975-84 trend of increased service needs per person—to about $132 billion in 1985 dollars by the year 2000 (see fig. 4.2).

Figure 4.2: Projected Spending for Long-Term Care Under Three Different Assumptions (1985-2000)



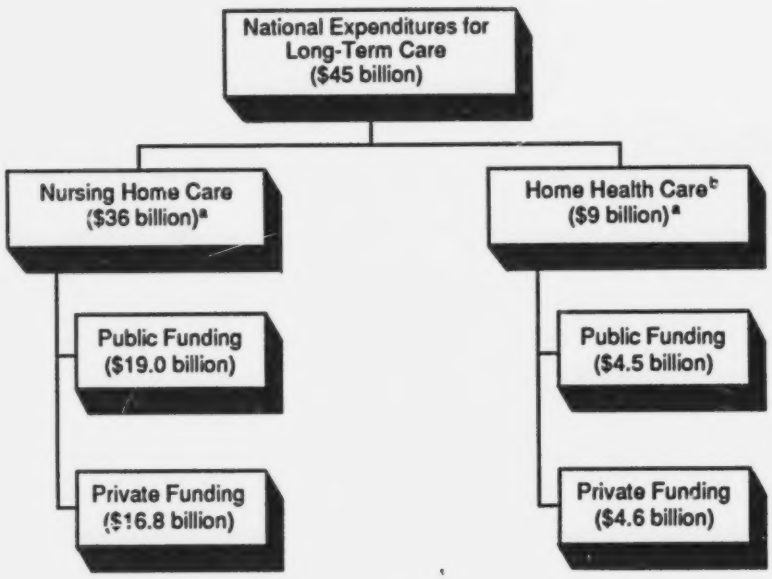
Source: Congressional Budget Office

Most Public and Private Long-Term Care Expenditures Pay for Nursing Home Care

In fiscal year 1985, as shown in figure 4.3, almost $36 billion (80 percent) of the estimated $45 billion spent nationally for long-term care was for nursing home care.[2] An additional $9 billion (20 percent) of these expenditures supported home health care (see fig. 4.3), over and above the care provided by informal caregivers. Nursing home care expenditures are the third largest U.S. health expenditure after hospital and physician expenditures. These nursing home expenditures have grown as a percentage of national health expenditures, from about 6.3 percent in 1970 to about 8.3 percent in 1985.

[2]Nursing home care includes services provided in skilled nursing facilities, intermediate care facilities, combinations of skilled and intermediate facilities, intermediate care facilities for the mentally retarded, and noncertified facilities providing some nursing care.

Figure 4.3: Long-Term Care Funding
(Fiscal Year 1985)


National Expenditures for Long-Term Care ($45 billion)
Nursing Home Care ($36 billion)[a]
Home Health Care[b] ($9 billion)[a]
Public Funding ($19.0 billion)
Private Funding ($16.8 billion)
Public Funding ($4.5 billion)
Private Funding ($4.6 billion)

[a]Numbers do not add because of rounding.

[b]Home health care includes nursing, speech therapy, physical therapy, occupational therapy, services provided by home health aides, and medical social services. Payments for other social services (adult day care, meals and transportation) are excluded.

In 1985, Medicaid accounted for $17.2 billion (90 percent) of publicly funded nursing home care; the federal government contributed $9.5 billion and state governments, $7.7 billion. Medicaid's overall long-term care expenditures were $18.2 billion in fiscal year 1985—about 77 percent of the public expenditures.

In contrast, Medicare's expenditures for nursing home care were less than 2 percent of total public and private expenditures in 1985. Medicare played a greater role in financing public expenditures for home health care, although its coverage is not oriented towards the chronically ill. Medicare accounted for just over half—$2.3 billion—of publicly paid home health care, which totaled $4.5 billion in fiscal year 1985. Medicare's home health expenditures are financed primarily through payroll taxes.

Other public expenditures for nursing homes and home health care include (1) state support for which there is no federal matching (such support totalled $.9 billion in fiscal year 1985, with $.4 billion going to nursing home care and $.5 billion going to home health services[3]) and (2) support from the Older Americans Act and the Social Services Block Grant.

There are significant variations among states in per capita spending (both federal and state) for long-term care.[4] Per capita spending for the elderly in fiscal year 1986 was the highest in New York, at $1,348. Spending for each elderly adult was more than $600 in Alaska, Delaware, the District of Columbia, Hawaii, Massachusetts, and Minnesota. Spending was lowest in Arizona, Florida, Iowa, Louisiana, Nevada, and Utah (where less than $250 was spent for each elderly person in fiscal year 1986). Per capita spending in the other states fell between these extremes. The variations can be attributed to factors such as price differentials in nursing home care (and Medicaid payment rates), Medicaid eligibility criteria, state per capita income, the percentage of the state's population that is elderly, and nursing home beds per population over 65 years of age.[5]

Out-Of-Pocket Payments Total $20 Billion

Out-of-pocket payments represent most of the private spending for long-term care services. In fiscal year 1985, out-of-pocket payments accounted for $16.2 billion (about 96 percent) of privately paid nursing home care; private sources—insurers and private organizations—paid $600 million (about 4 percent). In 1985, out-of-pocket payments were $3.7 billion (about 80 percent) for private home health care costs. Other private funding sources paid $900 million (about 20 percent). Although Medicaid expenditures for nursing home care have been increasing (326 percent between 1975 and 1985), the out-of-pocket payments for nursing home care have been increasing at a faster rate—420 percent between 1975 and 1985.[6] The distribution of spending by public and private expenditures is shown in table 4.1.

[3]N. Gordon, Congressional Budget Office, testimony before the U.S. House Budget Committee, Health Task Force (Oct. 1, 1987).

[4]D. Lipson and E. Donohoe, Focus on ..., George Washington University, Intergovernmental Health Policy Project (June 1988), p. 6.

[5]Lipson and Donohoe, Focus on ..., pp.6-7.

[6]D. Waldo, K. Levit, and H. Lazenby, "National Health Expenditures, 1985," Health Care Financing Review, Vol. 8 (Fall 1986), p. 17.

Table 4.1: Distribution of Nursing Home and Home Health Care Spending (1985)

Dollars in billions

Source of spending	Nursing home care[a] Spending	Nursing home care[a] Spending (in percent)
Medicaid:		
Federal	$9.5	27
State	7.7	22
Medicare	0.6	2
VA	0.8	2
State[b]	0.4	1
Out-of-pocket payments	16.2	45
Private insurers and private organizations	0.6	2
Total	**$35.8**	**100[d]**
	Home health care[c]	
Medicaid:		
Federal	$.6	7
State	.5	5
Medicare	2.3	25
VA, Older Americans Act, Social Services Block Grant	.6	7
State[b]	.5	5
Out-of-pocket payments	3.7	41
Private insurers and private organizations	.9	10
Total	**$9.1**	**100**

[a]Nursing home care includes services provided in skilled nursing facilities, intermediate care facilities, combinations of skilled and intermediate facilities, intermediate care facilities for the mentally retarded, and noncertified facilities providing nursing care.

[b]Other state funding consists mainly of Medicaid-related payments for which there is no federal matching.

[c]The home health services included are nursing care, speech therapy, physical therapy, occupational therapy, services provided by home health aides, and medical social services. Payments for adult day care, meals, and transportation services are excluded.

[d]Does not add to 100 because of rounding.

Medicare provides only limited long-term care coverage; in addition, less than 2 percent of the elderly have private long-term care insurance. Therefore, an elderly person's course of action if he or she encounters catastrophic costs for long-term care services (such as the cost of nursing home care, which averages $25,000 a year) is to pay for these expenses from their income and assets. Some who decide to purchase care may spend down their income and assets until they meet the eligibility criteria for Medicaid.

According to preliminary analysis of the 1982 and 1984 Long-Term Care Surveys, short stays in nursing homes have virtually no impact on the risk of becoming Medicaid-eligible. However, long stays greatly increase the risk of Medicaid spenddown;[7] that is, a person's using almost all of his or her income and assets to pay for nursing home care. The risk of a person 65 years of age and over staying in a nursing home for more than 1 year is generally low: This person faces a 13 percent chance of spending more than 1 year in a nursing home during the remainder of his or her lifetime. But this person also has a 56 percent chance of not spending any time in a nursing home.

When an elderly Medicaid-eligible person enters a nursing home, he or she, as well as a spouse, may retain only a portion of his or her monthly income. An elderly Medicaid resident of a nursing home must share in the cost of care by using all of his or her income, except for an allowance for "personal needs," ranging from $25 to $70 per month in 1987.[8,9]

A married nursing home resident is usually permitted to set aside a "maintenance" allowance for the noninstitutionalized spouse who has no or only limited income (in 1985, only 16 percent of the elderly entering nursing homes were married). This allowance has varied dramatically across states, ranging from $150 to $632 a month in 1987.[10,11] A new provision of the Medicare Catastrophic Coverage Act of 1988, which amended the Medicaid program, effective September 30, 1989,

[7]K. Liu and K. Manton, "The Effect of Nursing Home Use on Medicaid Eligibility," paper supported by grants from the Travelers Companies Foundation; HHS, Office of the Assistant Secretary for Planning and Evaluation, No. 87ASPE185A; HCFA, 18-C-98641; and the National Institute on Aging, AG07198 (Apr. 1988), p. 16.

[8]Increased to $30 per month as of July 1, 1988.

[9]E. Neuschler and C. Gill, Medicaid Eligibility for the Elderly in Need of Long-Term Care (Congressional Research Service, Sept. 1987), p. 22. The range is due to differences in Medicaid cost-sharing requirements, which vary from one state to the next.

[10]Oklahoma did not permit an allowance and Arizona did not provide Medicaid-paid nursing home care in 1987.

[11]Neuschler and Gill, Medicaid Eligibility, p. 48.

will greatly increase the amount of income and resources that an institutionalized person may retain for use by his or her spouse in the community.[12] This provision should help prevent the impoverishment of the noninstitutionalized spouse.

Federal Research on Financing and Delivery Reforms

There has been continued federal concern since the early 1970's about rising public expenditures for long-term care, specifically nursing home care. This has resulted in research efforts designed to test cost-effective alternatives to control costs through delivery reforms. The underlying theme of this research has been to test whether the expansion of home and community-based services could help the elderly remain in their own homes longer, thereby reducing the use of costly nursing home services.

The HHS demonstration projects of the 1970's and 1980's looked at whether substituting sets of home and community-based services for nursing home care would reduce long-term care costs and improve the quality of life for elderly participants.[13] Generally, the demonstrations (1) provided some form of case management (including assessment of needs, design of a plan of care, arrangement of services, and ongoing monitoring of clients) and (2) offered expanded long-term care services, funded through waivers of Medicaid or Medicare regulations or both. Most of the demonstrations were conducted at either one site or several sites within a given state. Samples varied considerably in size, ranging from 139 to 6,326 persons. Only one project, the National Long-Term Care Channeling Demonstration, had a large multi-state sample—10 sites in 10 states.

The results of the demonstrations often showed both increased aggregate costs and improved quality of life. Although expanded community-based services led to small reductions in nursing home costs for some people, these savings were more than offset by the increased costs of

[12]As of September 30, 1989, the maintenance allowance will equal 122 percent of the monthly federal poverty line for a 2-person household (that is, $959, using the 1988 poverty line of $786 per month for a 2-person family). This allowance will equal 133 percent as of July 1, 1991, and 150 percent as of July 1, 1992. In addition, the spouse in the community will be able to retain $12,000 in resources (or up to $60,000 at state option).

[13]This section is based on B. Haskins and others, Evaluation of Community-Oriented Long-Term Care Demonstration Projects, Pub. No. 03242 (HCFA, May 1985); "Community Care Demonstrations: What Have We Learned," Health Care Financing Review, Vol. 8 (Summer 1987), pp. 87-98; Medicaid: Determining the Cost-Effectiveness of Home and Community-Based Services (GAO/HRD-87-61, Apr. 1, 1987); and the Evaluation of the National Long-Term Care Demonstration, special issue of Health Services Research, Vol. 23 (Apr. 1988).

providing expanded home and community-based services to others who would have remained at home even without expanded services. The demonstrations were more successful in improving quality of life.

Capitated Financing Demonstrations

Current demonstrations include testing of the social health maintenance organization (S/HMO) concept, which gives one organization the lead in financing and integrating long-term care with other health services. This concept is based on the premise that (1) a case-managed continuum of care will be cost effective and (2) savings in acute care are sufficient to finance expanded home care.

S/HMO is a prepaid system that adds long-term care benefits, such as nursing home and homemaker services, to the usual Medicare benefit package provided by a regular HMO (a capitated financing system using the concept of prepayment). A S/HMO is paid premiums by both individual members and third parties (Medicare and Medicaid). It pools these premiums to pay for member services. In contrast to a system in which a provider is paid separately for each service supplied, the S/HMO provider is at risk and has a financial incentive to control the use of services. Currently, S/HMO demonstrations are under way in Long Beach, California; Minneapolis, Minnesota; Brooklyn, New York; and Portland, Oregon.

Another form of capitated financing system is the On Lok model. The provider is again at risk, but instead of serving a broad population of well and frail elderly like the other S/HMO demonstrations, the On Lok sites serve only the frail elderly. In 1979, On Lok Senior Health Services in California received extensive Medicare waivers to serve the frail elderly living within a geographically limited section of San Francisco—the Chinatown and North Beach area—by providing a comprehensive program of community-based services. In 1983, On Lok was modified to implement an at-risk capitated system. In 1986, under the Omnibus Budget Reconciliation Act of 1986, the Congress authorized additional demonstrations similar to On Lok. To provide comprehensive health care services on a capitated basis to frail elderly patients at risk of institutionalization, HHS can, under the act, grant waivers to up to 10 community-based organizations.

Other Demonstrations

Three other demonstration projects were authorized by the Omnibus Budget Reconciliation Act of 1986. The Alzheimer's Disease Demonstration Projects will (1) provide comprehensive services to Medicare beneficiaries with Alzheimer's disease and (2) determine the effectiveness and

cost of these services, as well as their impact on the health and functioning of beneficiaries. Services may include case management, respite care, adult day care services, and other in-home services. The Chronically Mentally Ill Demonstration Program allows states to implement programs to improve the continuity, quality, and cost effectiveness of mental health services to Medicaid beneficiaries who are chronically mentally ill. The New Jersey Respite Care Pilot Project will provide respite care services under the Medicaid program for elderly and disabled individuals in order to determine the extent to which these services (1) delay or avert the need for institutional care and (2) enhance and sustain the family's role in providing long-term care services to the elderly and disabled who are at risk of institutionalization.

State Financing and Delivery Reforms

Some states have also been experimenting with new strategies for financing and delivering long-term care. Oregon, for example, created a division within the Oregon Department of Human Resources responsible for all long-term care programs. Oregon's system provides home and community-based services on a sliding-fee basis to people over 60 years of age who have the same ADL and IADL dependencies as Medicaid-eligible clients, but do not meet financial eligibility criteria for Medicaid.

By increasing the centralization of long-term care administration between 1979 and 1986, Medicaid nursing home expenditures for the elderly in Oregon decreased both in absolute and relative terms. The state estimated that in 1986, the overall system (including nursing home and community-based services) experienced an 11 percent reduction, costing the state $13 million less than it would have spent if the system had not been changed. In 1986, total program expenditures (including nursing home care) were $102,328,423 to serve a monthly average of 17,324 cases.

Other states have also revamped their systems. In April 1988, the National Governors' Association, under a grant from HHS, issued its report on long-term care systems in Oregon and five other states—Arkansas, Illinois, Maine, Maryland, and Wisconsin. Like Oregon, each state (1) pooled multiple funding sources for home and community-based services and (2) consolidated long-term care management at the state level. In each state, access was organized through case management, preadmission screening, and assessment of clients. In several states, the ability of a family to provide informal care is considered in assessing the quantity and type of home care services to be provided. To ensure that some of the elderly would not be overlooked because of gaps

in eligibility, these states created a continuum of financial eligibility, providing services on a sliding-fee basis.[14]

According to the National Governors' Association study, these states have been able to expand home care services without generating uncontrolled growth of costs in total long-term care spending. Over a 5-year period, total costs have risen, averaging 6.2 percent annually per person aged 75 and older.[15]

Private Sector Approaches Not Widely Used

Concerns over high public and private expenditures for long-term care have also led to interest in using private sector mechanisms, which would help to defray the costs of care by generating new sources of revenue. There are two major types of private sector approaches: self-financing options and pooling of risks through insurance. A self-financing option, such as home equity conversions, encourages people to use their assets in new ways to pay for their future long-term care needs. Pooling risks over a group of people ranges from long-term care insurance—a financing mechanism—to continuing care retirement communities—combined financing and service delivery mechanisms.

Self-Financing Options

Home-equity conversion plans, that is, reverse mortgaging, allow a homeowner to convert the equity in a home (without having to move out) into monthly income that could be used for long-term care needs. These conversions can provide the elderly with money to pay directly for long-term care services of their choice and for long-term care insurance as well. Approximately 75 percent of the elderly own their own homes; the average net home equity of elderly homeowners was about $54,000 in 1987 dollars. There has been a lack of consumer interest in this approach, however; as of 1987, only about 2,000 reverse mortgages had been effected.[16]

Long-Term Care Insurance

Private long-term care insurance attempts to spread long-term care costs over a broad population. Such insurance policies, although becoming more available, are held by just a small number of elderly. These policies

[14]D. Justice and others, State Long-Term Care Reform, Development of Community Care Systems in Six States (National Governors' Association, Apr. 1, 1988), p. 74.

[15]Justice and others, State Long-Term Care Reform, p. vii.

[16]A. Rivlin and J. Wiener, Caring for the Disabled Elderly, Who Will Pay? (Washington, D.C.: The Brookings Institution, 1988), p. 123.

often provide only partial coverage for extended nursing home care or home care costs. As of April 1987, about 420,000 private long-term care insurance policies were in effect, more than double the estimated 200,000 policies in effect in mid-1986. Assuming that most policyholders are 65 years of age and over, this represents only about 1-1/2 percent of the elderly. In addition, even using favorable assumptions about the future growth of private long-term care insurance, one study suggests that two-thirds of the elderly will remain unable to afford this insurance by 2016-20.[17]

In 1986, more than 70 companies sold long-term care insurance policies or had policies approved for sale by state insurance departments.[18] GAO analyzed 33 policies, offered by 25 insurers in 1986, which provided indemnity payments—fixed dollar amounts paid per eligible day of coverage. GAO found that in general, policies contain restrictions and limitations that tend to reduce the benefits available to policyholders; for example, policyholders may have to share in the cost of the care they receive because of waiting periods and other benefit limitations.

Several factors explain the current low rate of long-term care insurance coverage among the elderly:

- the belief by a segment of the population that Medicare and Medigap insurance already cover long-term care costs and that Medicaid is a free long-term care program;
- the fact that for the most part, long-term care insurance policies have been sold to individuals, making them more expensive than if marketed to groups; and
- the risk of adverse selection, that is (1) those most in need of this care are most likely to purchase insurance and (2) the likelihood that individuals, once they pay for long-term care insurance coverage, are more likely to use it.[19]

[17]Rivlin and Wiener, Caring for the Disabled Elderly, p. 59.

[18]Long-Term Care Insurance: Coverage Varies Widely in a Developing Market (GAO/HRD-87-80, May 29, 1987), pp. 17 and 33.

[19]K. Davis and D. Rowland, Medicare Policy: New Directions for Health and Long-Term Care (Baltimore, Md.: The Johns Hopkins University Press, 1986), p.91; J.K. Knickman and N. McCall, "A Prepaid Managed Approach to Long-Term Care," Health Affairs (Spring 1986), pp.91-92; and Employee Benefit Research Institute, "Financing Long-Term Care," Issue Brief, No. 48 (Nov. 1985), p.9.

Continuing Care Retirement Communities

Continuing care retirement communities is a second category of risk-pooling mechanism that represents a small but growing alternative in the private sector. In a 1986 survey, 683 communities were identified;[20] they housed an estimated 100,000 to 200,000 elderly residents.[21] The communities generally combine residential living for the elderly with access to nursing home care and other services. In 1987, however, only one-third of the communities pooled the financial risks for residents and guaranteed a broad range of health services in their contracts.

Although there has been growing interest in these communities, their high costs make them accessible to just a small proportion of the elderly; a 1984 study found that only 13 percent of people over 75 years of age, the age of those who typically enter a community, have sufficient income and assets to enter such a community. Today, less than 1 percent of the elderly live in these communities, and the high costs of developing such communities could prevent widespread expansion. In addition, there have been concerns over financial risks incurred by the consumer if a continuing care retirement community faces financial problems.[22]

The median entry fee for a 1-bedroom apartment was estimated to be $47,927 in 1987 dollars for one person, and the median monthly fees were an estimated $756 a person, according to a 1986 survey.[23] Usually, a nursing home is located on or near the community campus, and elderly residents can receive a continuum of care, within the same community, as their needs change. But in some cases, fees are charged for the use of these additional long-term care services. The residents in continuing care retirement communities are, on average, aged 80 or over; 70 percent of all the residents are women, and more than half have no living children.[24]

[20]American Association of Homes for the Aging and Ernst and Whinney in S. Sherwood and others, "Continuing Care Retirement Communities; An Option for Aging in Place" (paper supported by HCFA grant, Feb. 1988), p. 7.

[21]American Association of Homes for the Aging and C. Estes and P. Lee in Sherwood, "Continuing Care," p. 7.

[22]Rivlin and Wiener, Caring for the Disabled Elderly, pp. 89 and 90.

[23]American Association of Homes for the Aging and Ernst and Whinney in Rivlin and Wiener, Caring for the Disabled Elderly, pp. 85-6.

[24]Sherwood and others, "Continuing Care Retirement Communities," pp. 15-16.

Chapter 5

Concluding Observations

Despite different estimates of how many elderly need long-term care (due to variations in how researchers use measures of functional dependency), it is clear that the number of dependent elderly will continue to increase. Researchers have estimated that in 1985, 6.2 to 6.5 million elderly needed some level of long-term care; between 1.3 and 1.6 million were estimated to be very dependent, with five or more ADL dependencies. The number of dependent elderly is projected to increase to 14.3 million by 2020.

Today's dependent elderly rely heavily on informal care from family and friends. But despite this help, a 1982 survey showed that about 40 percent of the dependent elderly in the community still had unmet care needs. These unmet needs may grow in the future as the availability of informal caregivers declines because of societal and demographic factors.

In the future, a larger proportion of the dependent elderly will have to rely on formal services. However, there are some elderly who currently are not able to pay for these services and who have trouble getting care because public programs provide only limited long-term care benefits. For others, care is difficult to obtain because of the sometimes tight supply of nursing home and home care. The availability of formal long-term care will have to increase to provide services that informal caregivers now provide.

Long-term care costs are also expected to rise as the population ages, affecting individuals and public programs alike. Through federal demonstrations, the government continues to look for less expensive ways of delivering long-term care through public programs; results to date have shown this to be an elusive goal. The future elderly, who might have to rely more on formal services, may be unprepared for long-term costs since relatively few individuals currently use risk-pooling mechanisms such as insurance.

Current issues in long-term care—access concerns and interest in new ways of financing and delivering long-term care services—are likely to continue, given demographic realities. Any future strategy for handling the growing long-term care needs of the elderly population will need to balance the potentially conflicting goals of access and cost containment. These strategies will have to be sensitive to estimates of the need for long-term care. Because of different definitions of disability, these estimates can vary, especially for levels of dependency.

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Key Features of the Medicare Catastrophic Coverage Act of 1988

Long-Term Care

Skilled Nursing Care

Current Law: Medicare covers up to 100 days in a skilled nursing facility for each spell of illness. It pays for all covered services during the first 20 days; from the 21st to the 100th day, it pays for all covered services except for $67.50 per day.

New Law: Medicare will cover up to 150 days in a skilled nursing facility for each calendar year. It will pay for 80 percent of the costs of covered services for the first 8 days of care in a skilled nursing facility each year and 100 percent of the costs of covered services from the 9th through the 150th day. The coinsurance is estimated to be $22.00 per day in 1989.

Effective January 1989.

Respite Care

Current Law: None

New Law: Medicare will pay for up to 80 hours a year for an outside aide to relieve family and friends who are taking care of a beneficiary. The beneficiary must (1) be dependent in two ADLs and (2) meet either the catastrophic limit for part B physician expenses or the prescription drug deductible for outpatients.

Effective January 1990.

Home Health Care

Current Law: Medicare pays the full approved cost of daily home health care visits for a short period, usually limited to 2 to 3 weeks. To qualify, beneficiaries must be homebound, under a physician's care, and require (1) part-time or intermittent skilled nursing care or (2) physical or speech therapy. Medicare will also pay for occupational therapy, part-time services of a home health aide, and certain medical social services and medical supplies for qualifying beneficiaries.

New Law: Medicare will pay the full approved cost of one or more home health care visits for 38 consecutive days.

Effective January 1990.

Hospice Care	Current Law: Medicare pays for up to 210 days of hospice care in a beneficiary's lifetime. New Law: The 210-day limit is eliminated. Effective January 1989.
Outpatient Prescription Drug Benefits	Current Law: None New Law: Medicare will share in the cost of prescription drug expenses for outpatients after a deductible is met. The deductible, $600 in 1991, will be adjusted each year. Medicare will pay 50 percent of prescription drug costs in excess of the deductible in 1991, 60 percent in 1992, and 80 percent in 1993 and subsequent years. Effective January 1991.

Acute Care

Hospital Inpatient Coverage	Current Law: From the 1st through the 60th day of hospitalization for each spell of illness, Medicare will pay all covered services after the beneficiary meets a deductible, which is $540 for 1988. From the 61st through the 90th day for each spell of illness, the beneficiary pays $135 per day (the copayment in effect for 1988); Medicare pays the balance of all covered services. For stays longer than 90 days, a beneficiary has 60 lifetime reserve days. For each reserve day used, the beneficiary copayment is $270 in 1988; Medicare pays the balance of covered services. New Law: After an annual deductible, estimated to be $560 in 1989, Medicare will pay for all covered services. Effective January 1989.
Physician and Other Health Care Services	Current Law: After the beneficiary meets a $75 annual deductible, Medicare pays for 80 percent of approved charges.

New Law: Same deductible and copayments. However, a beneficiary's share of approved charges will be limited to a specified ceiling ($1,370 in 1990, to be adjusted each year). Medicare will pay for all approved charges above the ceiling amount.

Effective January 1990.

Medicare Premiums

Part A

Current Law: Individuals entitled to Medicare pay no premiums.

New Law: To pay for expanded part A benefits, including nursing home and home health care, the Medicare Catastrophic Coverage Act provides for a supplemental Medicare premium in the form of a federal income tax surcharge on Medicare beneficiaries. Only beneficiaries who have an income tax liability of $150 or more must pay this tax.

Effective in 1989, the surtax will equal $22.50 for each $150 of federal income tax liability. The surtax will gradually increase until 1993, when it will be $42 for each $150 of tax liability. The maximum surtax per beneficiary will be $800 in 1989; it will gradually increase to $1,050 by 1993.

Part B

Current Law: Those who elect to enroll pay a monthly premium, $24.80 in 1988, increasing to $27.90 in 1989.

New Law: Medicare part B premiums will be increased to pay for expanded catastrophic coverage and prescription drug benefits. Beginning in 1989, a catastrophic coverage premium will be added. This premium will be $4.00 a month in 1989, rising to $7.18 a month in 1993. An additional monthly premium will be charged for the new prescription drug benefit. This premium will be $1.94 in 1991, rising to $3.02 in 1993.

Major Contributors to This Report

Human Resources Division, Washington, D.C.	Janet L. Shikles, Associate Director (202) 275-5451 Sheila M. Smythe, Chief Health Policy Adviser Robert E. Burke, Senior Health Policy Adviser
New York Regional Office	Anthony P. Lofaro, Issue Area Coordinator Nancy J. Donovan, Evaluator-in-Charge Preeti S. Jain, Evaluator John E. Riley, Evaluator Cynthia L. Sherwood, Evaluator

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